DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF11022 (Rev. 05/03)

WISCONSIN MEDICAID
RURAL HEALTH CLINIC STATISTICAL DATA

1. REPORTING PERIOD	Date from	Date to

2. RURAL HEALTH CLINIC INFORMATION

Name — Rural Health Clinic (RHC)	RHC Medicaid Provider Number	Non-RHC Medicaid Provider Number(s)

Address (Street / P.O. Box)	City	State	Zip Code

3. CONTACT(S)

Individual who should receive notices of adjustments, settlements, and other correspondence

Name	Title	Telephone Number	Fax Number

Individual who can be contacted if information is required concerning details of this cost report

Name	Title	Telephone Number	Fax Number

4. MEDICAID-CERTIFIED PROVIDERS EMPLOYED OR CONTRACTED BY THE CLINIC

List the name, provider specialty, and Medicaid performing provider number of all providers employed or contracted by the clinic during this reporting period. Include information for all Medicaid-certified providers.

Note: Any new enrollments or changes (terminations or corrections) should be made by contacting Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Name — Provider	Specialty	Individual Medicaid Provider Number

5. CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

I hereby certify that I have examined this cost report and accompanying forms for the period noted. To the best of my knowledge and belief it is a true, correct, and complete statement prepared from the books and records of the RHC, in accordance with applicable instructions, except as noted.

SIGNATURE — Officer or Administrator of Clinic	Date Signed

Reset Form